In the Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

Brief of the Participants in the Kaiser-Permanente Medical Care Program as *Amici Curiae*

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This brief is filed on behalf of the Kaiser-Permanente Medical Care Program (the "Program"),[1] with the written consent of all parties to this proceeding pursuant to Rule 42 of the Court.

1. The specific entities which together constitute the Program are: Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Oregon, Kaiser Foundation Health Plan of Colorado, Kaiser Community Health Foundation, Kaiser Foundation Hospitals, The Permanente Medical Group, Southern California Permanente Medical Group, Northwest Permanente, P.C./Physicians & Surgeons, Colorado Permanente Medical Group, Ohio Permanente Medical Group, Hawaii Permanente Medical Group, Inc., Permanente Services, Inc., Southern Permanente Services, Inc., Permanente Services of Oregon, Inc., Permanente Services of Hawaii, Inc., Permanente Services of Colorado, Inc., and Ohio Permanente Services, Inc.

NATURE OF THE INTEREST OF AMICI CURIAE

The Program is a nonprofit, prepaid health care insurance system that serves over three million enrolled members in six geographical regions. The Program is a prototype Health Maintenance Organization ("HMO"). As such it arranges and provides to its members comprehensive, prepaid health care at Program facilities. Covered services include hospital, physician, pharmaceutical and related health services. The Program has been formally qualified under the Health Maintenance Organization Act of 1973 ("HMO Act"), 42 U.S.C. § 300e, *et seq.*[2]

Several of the Program organizations were sued in cases currently on appeal from the United States District Court for the Central District of California to the Court of Appeals for the Ninth Circuit (the "PRDA cases").[3] The PRDA cases were ostensibly filed on behalf of all retail drug stores in the states of California, Washington and Oregon, and allege that the Program organizations have violated certain federal antitrust laws, specifically Section 2(f) of the Robinson-Patman Act, 15 U.S.C. § 13(f), and Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2,

2. Under the HMO Act, an "HMO" is technically an organization that accepts contractual responsibility to arrange health services in return for premium payments. Some HMOs directly employ physicians and own hospitals, but many do not. The term "HMO" is perhaps more commonly used to identify not only the enrollment organization, but also the related physicians, hospitals and other health care providers that operate as components of an integrated health care delivery system, even though they may represent legally separate organizations. We use the term in this broader sense.

3. The cases are *Portland Retail Druggists Ass'n, Inc. v. Kaiser Foundation Health Plan,* (Civil No. 77 1485-IH) and *DeModena v. Kaiser Foundation Health Plan,* (Civil No. 77 0005-IH). Some of the sales in question are the subject of an action by retail pharmacists against drug manufacturers and were considered by the Court in *Abbott Laboratories v. Portland Retail Druggists Ass'n, Inc.,* 425 U.S. 1 (1976).

by (1) knowingly inducing or receiving discriminatorily low prices for drug products, (2) attempting to monopolize the retail drug market, and (3) "tying" the sale of prescription drugs to the sale of other prepaid health care services. Summary judgment was entered in favor of the Program organizations (1) as to all claims on the grounds that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, withdraws the Program from regulation under the federal antitrust laws, (2) as to the Robinson-Patman Act claims on the grounds that the Program is entitled to the protection of the Nonprofit Institutions Act, 15 U.S.C. § 13c, and (3) as to the Sherman Act claims on the basis that there was a lack of predatory conduct or specific intent to monopolize, that no illegal tying exists, and that plaintiffs failed to state a claim upon which relief could be granted.

While there are significant differences between the form of organization and method of operation of the Program and that of the Blue Shield petitioners in this case, the position taken by the Court with respect to the exemption afforded by the McCarran-Ferguson Act may have considerable impact on the services provided by HMOs, like the Program, and may have relevance to the issues on appeal to the Ninth Circuit in the PRDA cases. For these reasons, and as elaborated upon hereinafter, *amici curiae* are vitally interested in the issues presented to the Court for its decision.

ARGUMENT

Congressional Policy Promoting HMOs Should Not Be Curtailed by a Narrow Interpretation of the McCarran-Ferguson Act.

The inability of the traditional fee-for-service sector of the health care economy to provide quality health care services at a reasonable cost has stimulated Congressional encouragement to establish and expand alternate forms of

health care delivery systems. The staggering increases in health care costs over the last decade have been documented by a host of authorities. In setting forth its report on the proposed HMO Act, the Senate noted that national health expenditures rose by 188 percent in the eleven year period from 1960 to 1971. S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033. The Senate Report indicated that a large portion of the cost increases went to meet the "continuing inflation" of health care prices and "to subsidize inefficiency and waste in the delivery of health care services." *Id.* Further, the traditional health care "system" was seen as relatively indifferent to preventive care and the early treatment of disease and as relying on costly and intensive hospital care when treatment was finally sought. *Id.*

The federal government has been involved with issues relating to rising health care costs both in its role as a regulator and in its role as a purchaser of health care services. During the past several decades, government has become a principal purchaser of health care services.[4] As a purchaser of health care services, the government has been hit by rising costs and recent legislation evidences an increasing concern with the cost of such purchases.[5]

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4. Prior to Medicare and Medicaid, government at all levels paid about 24% of the national health bill. Today it pays 42%. Since 1965, health expenditures as a percent of the gross national product have increased from 5.9% to 8.6%. Gibson, Robert M., and Mueller, Marjorie Smith, "National Health Expenditures, Fiscal Year 1976," *Social Security Bulletin,* Social Security Administration, DHEW 40 (4), Table 1 at 4 (April, 1977). It was estimated that during 1977 the federal government would infuse about $46 billion into the private health care sector.

5. This concern has been manifested through (a) requirements for reviewing the need for continued hospitalization of patients covered under Medicare and Medicaid, 42 U.S.C. § 1320c; (b) restrictions on expansion of health care facilities and services, 42 U.S.C. § 1320a-1; (c) fraud squads to catch Medicaid cheats, 42 U.S.C. § 3521-3527; and (d) the Administration's current proposals to limit increases in hospital's annual income to 9% and to impose a national limit on new capital expenditures for acute care hospitals, Hospital Cost Containment Act of 1977, S. 1391 and H.R. 6575, 95th Cong., 1st Sess.

In addition to direct efforts to cut federal expenditures for health care, Congress also has sought to encourage development of alternative health care delivery systems which are considered to have potential for reducing inflation in health care costs. These efforts are seen not only as a way to lessen the government's financial burden as a health care purchaser, but also as a way to reduce expenditures by the consuming public. Congress found that HMOs have an inherent cost efficient tendency. S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3034. In discussing the benefits to be provided through the HMO form of organization, the Senate Report stated:

> The fixed price concept for comprehensive services provides a strong financial incentive to physicians, hospitals and other institutional providers of health care services to place greater emphasis on preventive services to avoid the need for costly, intensive care which can reduce their income. At the same time, HMO's are motivated to function more efficiently since the cost of wasteful and inefficient practices cannot be passed on to the consumer or to third party payers. *Id.*

In addition, the HMO was seen by Congress as organizing medical resources in a convenient and responsive manner and as providing substantial economic and professional advantages to participating physicians. *Id.* at 3034 and 3041.

The ability of HMOs, such as the Program, to provide high quality care at low cost has been recognized in studies by universities, government agencies, commissions engaged in research, and other research organizations. The Report

of the National Advisory Commission on Health Manpower, for example, concluded that "the cost to the average person who obtains medical care through Kaiser is 20-30 percent less than it would be if he obtained it outside." II *National Advisory Commission On Health Manpower, Report* (1967) 206-7. Results of other studies indicating the lower total health care costs of Program members are summarized in Exhibit 1 hereto. Cost savings of HMOs, such as the Program, are in part obtained through lower hospital utilization. These savings are primarily a result of the Program's comprehensive benefit structure that emphasizes ambulatory care for its members, combined with economic incentives that encourage physicians to use the most appropriate, not the most expensive, method of treatment. Exhibits 2-4 hereto illustrate the considerable savings in hospitalization that the Program has achieved.

In response to substantial evidence presented to it concerning the savings provided by HMOs and the benefits to society to be obtained through them, Congress adopted the HMO Act as a means of encouraging and regulating the development of the HMO.[6] As structured by the HMO Act,

6. HMOs are also subject to extensive regulation under state law. Illustrative of the types of regulations that have been enacted by the states which are applicable to HMOs are the following laws of the states of California, Oregon and Washington which, *inter alia*, require the licensing of health plans, Cal. Health & Safety Code §§ 1340-1399.5; regulate the financial capability and responsibility of health plans, Cal. Health & Safety Code §§ 1342(d) and 1372(1), Or. Rev. Stat. § 731.574, Wash. Rev. Code § 48.44.160(2); and regulate a plan's contracts with its members and the providers of services, Cal. Health & Safety Code § 1367(h), Or. Rev. Stat. § 731.012, Wash. Rev. Code §§ 48.44.010(4), 48.44.020(2), and 48.44.070. Further, some state laws regulating HMOs also make specific reference to laws relating to unfair business practices and unfair competition or provide for sanctions and disciplinary actions for violation thereof. Cal. Health & Safety Code §§ 1386(a), (b)(7) and (9) and Or. Rev. Stat. §§ 731.418(b), 731.988, and 731.992.

an HMO in effect provides a new kind of insurance in the health care area. To qualify under the HMO Act, an HMO must provide the health care services directly, not simply reimburse the insured for services he obtains from other health care providers. The Act requires HMOs to have a fiscally sound operation and to "assume full financial risk on a prospective basis for the provision of basic health services," subject to an ability to obtain reinsurance or to take other measures to offset only a portion of the cost. 42 U.S.C. § 300e(c)(1) and (2); *see also,* S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3045-6.

The HMO Act institutionalizes a number of structural requirements designed to insure that HMOs act in consumers' best interests. First, the HMO Act requires HMOs to establish their rates under a "community rating" method under which all enrollees pay the same rate for the same contract benefits, and does not permit "rating up" based on actual utilization of health care services. With community rating, groups whose members include those least able to afford health insurance, *e.g.,* the aged and chronically ill, can obtain HMO coverage at the same cost as other subscribers. 42 U.S.C. § 300e(b)(1)(C), *see also,* S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3061. Second, the HMO Act requires that financially stable HMOs have annual open enrollment periods during which they must accept all applicants without regard to their previous health history. 42 U.S.C. § 300e(c)(4) and (d), *see also,* S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3061. In addition, HMO enrollees must have a substantial representation on the HMO's governing body. 42 U.S.C. § 300e(c)(6).

As originally enacted, the HMO Act recognized "basic" health services, which the HMO was required to include as covered benefits for all enrollees, and "supplemental" health services, which the HMO was required to make available as optional benefits. The basic health services included physician services, inpatient and outpatient hospital services, medically necessary emergency health services, diagnostic laboratory services and other related services. Outpatient prescription drugs were included as a supplemental benefit. 42 U.S.C. § 300e-1(1) and (2).

The importance of HMOs' providing drugs as part of their comprehensive health care system was described in the Senate Report on the HMO Act:

> . . . each HMO must provide prescription drugs either directly or through arrangements with others. It is intended that this requirement will result in the rational use of the appropriate and most efficient prescription drug preparation in a particular situation. In providing drug services, the Committee expects that the HMO will establish patterns of patient-drug utilization, and will utilize the services of clinical pharmacologists, or pharmacists qualified to evaluate the appropriateness of drug usage within the HMO.
>
> The requirement that a clinical pharmacist survey, evaluate, and review patterns of patient drug utilization (including drug regimens and therapies) and maintain a drug use profile for each enrollee of an HMO is intended to ensure the input of a drug specialist into the development of a rational drug therapy for each patient. The Committee expects such a pharmacist to be one who has had substantial training and experience in designing and monitoring patient drug therapy.
>
> In addition, the clinical pharmacist is expected to play a major role in disseminating important drug use and abuse information, both to the HMO staff and the

> member patients. (S. Rep. No. 93-129, 93rd Cong., 1st Sess., *reprinted in* [1973] *U.S. Code Cong. & Ad. News,* 3033, 3042-43.)

In an effort to make the HMO benefit structure more flexible, the mandatory service requirement was relaxed in regard to drugs and a number of other health services by the 1976 amendments to the HMO Act. Nevertheless, supplemental benefits, including pharmaceuticals, are still considered important. The House Report commented concerning the import of the 1976 amendments: "While these amendments will no longer require HMO's to deliver any particular supplemental health service, it is the Committee's hope that, where a group of members desires to contract for a listed service and the necessary health manpower is available, the HMO will make every effort to provide that service." H. Rep. No. 94-518, 94th Cong., 2nd Sess., *reprinted in* [1976] *U.S. Code Cong. & Ad. News,* 4312, 4328. When an HMO contracts to provide a supplemental benefit to its members, the benefit is an integral part of the HMO's overall health care program.

By actually providing their members with health care, HMOs perform a service distinctly different from the predominately financial function (claims paying) of conventional indemnity insurers. With respect to HMOs which purchase drugs and provide them to their members directly, there is an even closer nexus between the insurer and the insured than under Blue Shield-type plans, because the HMO itself is immediately responsible for the availability, cost and quality of care provided. In fact, most Program enrollees are covered under prepaid prescription drug programs.

The HMO Act requires employers to offer a qualified HMO, if one exists in the area, as one of the options avail-

able under their health benefits programs. 42 U.S.C. § 300e-9. The HMO Act thus supports a new source of competition in the health care area and thereby makes an effort to combat rising health care costs in general.

The FTC Staff recently investigated the competitive impact of HMOs on the traditional fee-for-service sector. The summary of the Report states:

> This study tests the hypothesis that the presence of an HMO in an area can have a competitive impact upon the traditional fee-for-service sector . . . The results of the study provide evidence that a significant HMO presence may help lower costs not only to HMO subscribers, but to others in the area, as well. We conclude that the HMO can play a significant economic role in this segment of the health care industry. . . .

Bureau of Economics, *FTC Staff Report on the Health Maintenance Organization and Its Effects on Competition*, vi.

Other existing and proposed federal legislation similarly encourages HMOs. For example, under the Social Security Act, an HMO may elect to be compensated on a basis in which it shares in savings that it realizes in caring for Medicare beneficiaries. 42 U.S.C. § 1395mm. The same legislation authorizes states to provide health services to Medicaid enrollees through prepaid contracts with HMOs. 42 U.S.C. § 1396a(a)(23). Further, under the Administration's proposed Hospital Cost Containment Act of 1977, HMO hospitals would be exempt from the Act's limits on hospital reimbursement and capital expenditures. S. 1391 and H.R. 6575, 95th Cong., 1st Sess.

In short, national policy is to encourage HMO-type programs.

The Congressional objectives in enacting the HMO Act will be jeopardized if HMOs may not observe the Act's

requirements without the overhanging threat of antitrust litigation. As indicated by the PRDA cases, a number of activities necessarily carried on by HMOs might be regarded as subject to attack under the federal antitrust laws absent an exemption. Congress clearly was aware of the existence of the federal antitrust laws when it passed the HMO Act. It must be assumed that it did not intend on the one hand to require or encourage an HMO to engage in certain types of activities and then prohibit those same activities under the federal antitrust laws. The application of the McCarran-Ferguson Act exemption to HMOs brings the federal antitrust laws into harmony with the HMO Act and is consistent with prior interpretations of the scope of the exemption.

In deciding this case, the Court should recognize that any limitation on the scope of McCarran-Ferguson Act exemption may also affect direct health care providers, such as HMOs. In the face of a clear Congressional intent that HMOs be encouraged to provide comprehensive health care, including pharmaceuticals, to their members at reasonable prices, any decision which would restrict the provision of services by HMOs should be carefully evaluated.

CONCLUSION

For the reasons set forth herein, *amici curiae* urge the Court to reverse or expressly limit the decision of the Fifth Circuit in the *Royal Drug* case. Any other result could have vast ramifications with respect to the delivery of health care by HMOs as required under the HMO Act.

DATED: May 12, 1978.

Respectfully submitted,

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(Exhibits follow)

Exhibit 1

A UCLA study published in 1975 found the following health care costs for persons enrolled in six prepaid plans, including the Program, in Southern California in 1967:[7]

Health Care Expenses
By Members of Prepayment Plans
Los Angeles County, 1967

Plan	Annual Per Capita Expenses — Out-of-Pocket	Annual Per Capita Expenses — Total
Blue Cross	$108	$235
Blue Shield	$ 74	$230
Large Insurance Company	$ 79	$183
Small Insurance Company	$ 69	$160
Small Group Practice	$ 50	$142
The Program	$ 13	$124

A federal study published in 1975 showed the following average Medicare payments in 1970 for Program members and for member-matched control groups residing in the same area and receiving service under fee-for-service mechanisms:[8]

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7. Hetherington, Robert W., Hopkins, Carl E., and Roemer, Milton I., *Health Insurance Plans: Promise and Performance,* Table 5-1 at 204 and Table 5-5 at 223 (1975).

8. Corbin, Mildred, and Krute, Aaron, "Some Aspects of Medicare Experience with Group-Practice Prepayment Plans," *Social Security Bulletin,* Social Security Administration, DHEW 38(3), Table 1 at 7 (March 1975).

Exhibit 1 (Continued)

Total Medicare Reimbursement for Health Plan Members Compared to Control Populations, 1970

Program Region	Reimbursement per Beneficiary — Program Members	Control Population	Program Cost Lower By
Southern California	338	414	18%
Northern California	331	406	18%
Oregon	226	337	33%

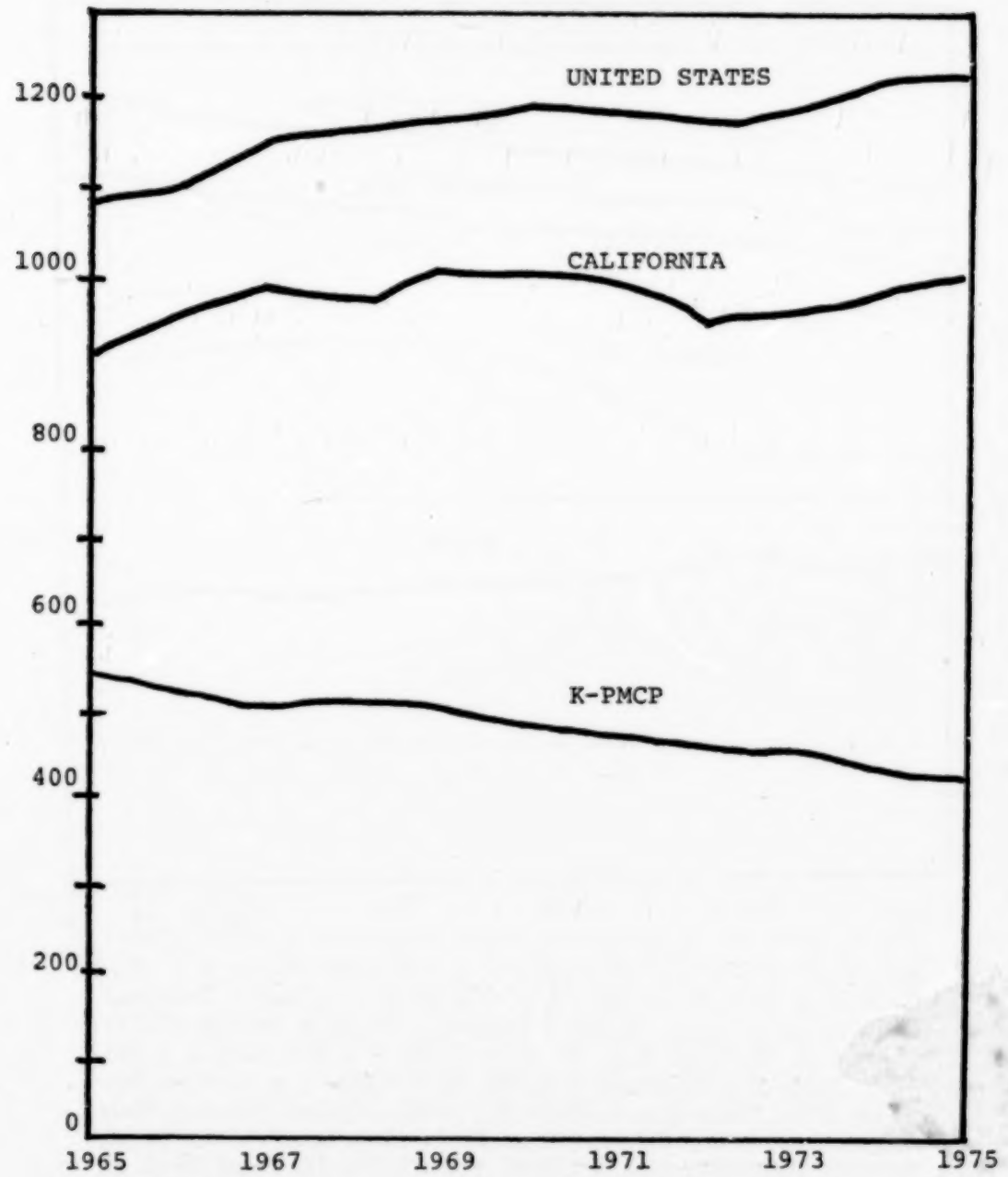
A 1970-71 survey of consumer experience under the State of California employees' Medical and Hospital Care Act showed:[9]

	Kaiser-Permanente: California Regions	State-Wide Service Plans	State-Wide Indemnity Plans	Individual Practice Plans
Average Number of Beneficiaries	89,000	72,000	92,000	5,000
Annual Expenses Per Family				
Total Premiums	$350	$372	$280	$351
Out-of-Pocket Expenses	90	188	203	249
Total Expenses	$440	$560	$483	$600

9. Dozier, Dave, *et al., 1970-71 Survey of Consumer Experience Report of the State of California Employees' Medical and Hospital Care Program* (prepared under the policy direction of the Medical Advisory Council to the Board of Administration of the Public Employees' Retirement System) Table 31 at 99 (May 1973).

Exhibit 2

I. PATIENT DAYS PER 1,000 PERSONS PER YEAR[10]

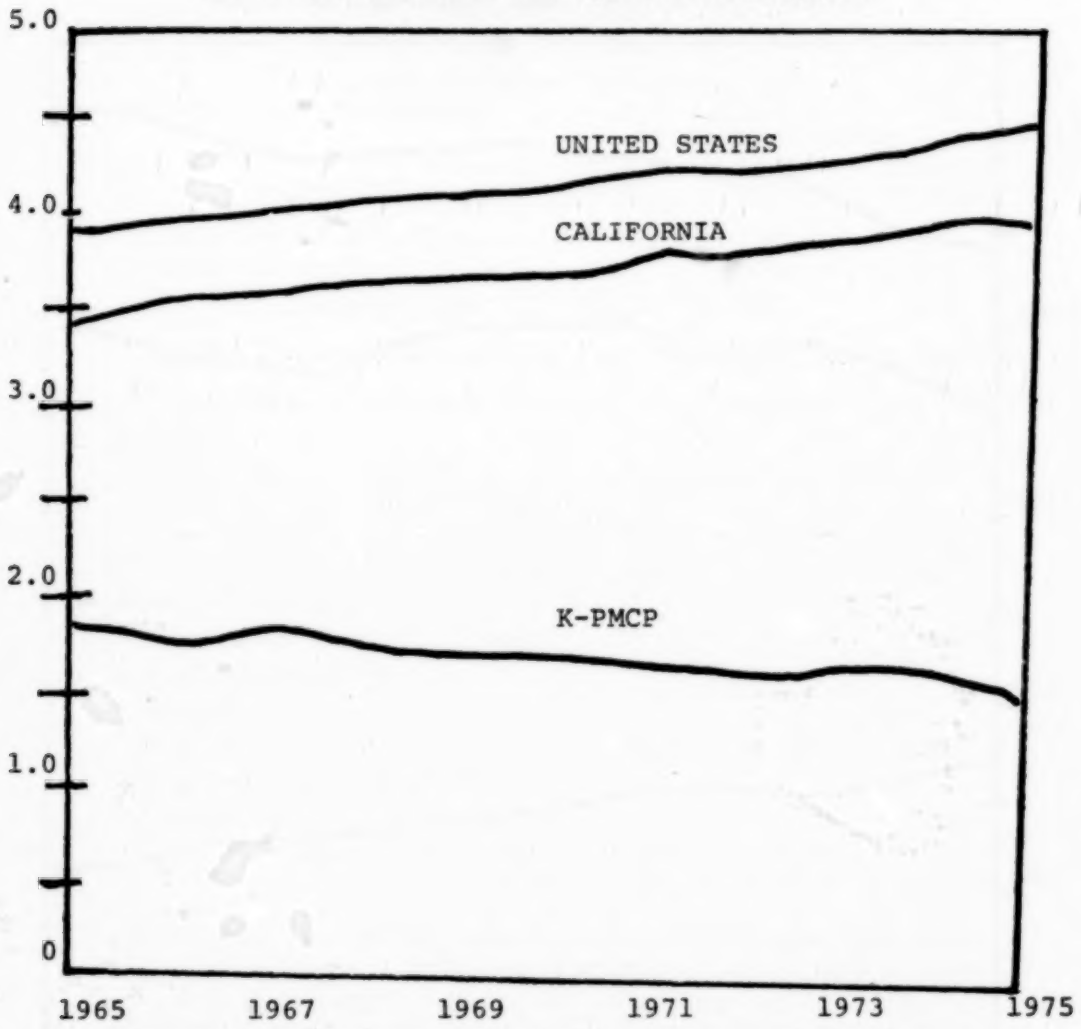


10. United States and California hospital data are from American Hospital Association, *Guide to the Health Care Field, Part 2,* Chicago, Illinois (1965: Table 1, p. 439; Table 3, p. 464; 1966: Table 1, p. 453; Table 3, p. 468; 1967: Table 1, p. 449; Table 3, p.

[continued on next page]

Exhibit 3

II. HOSPITAL BEDS PER 1,000 POPULATION[11]

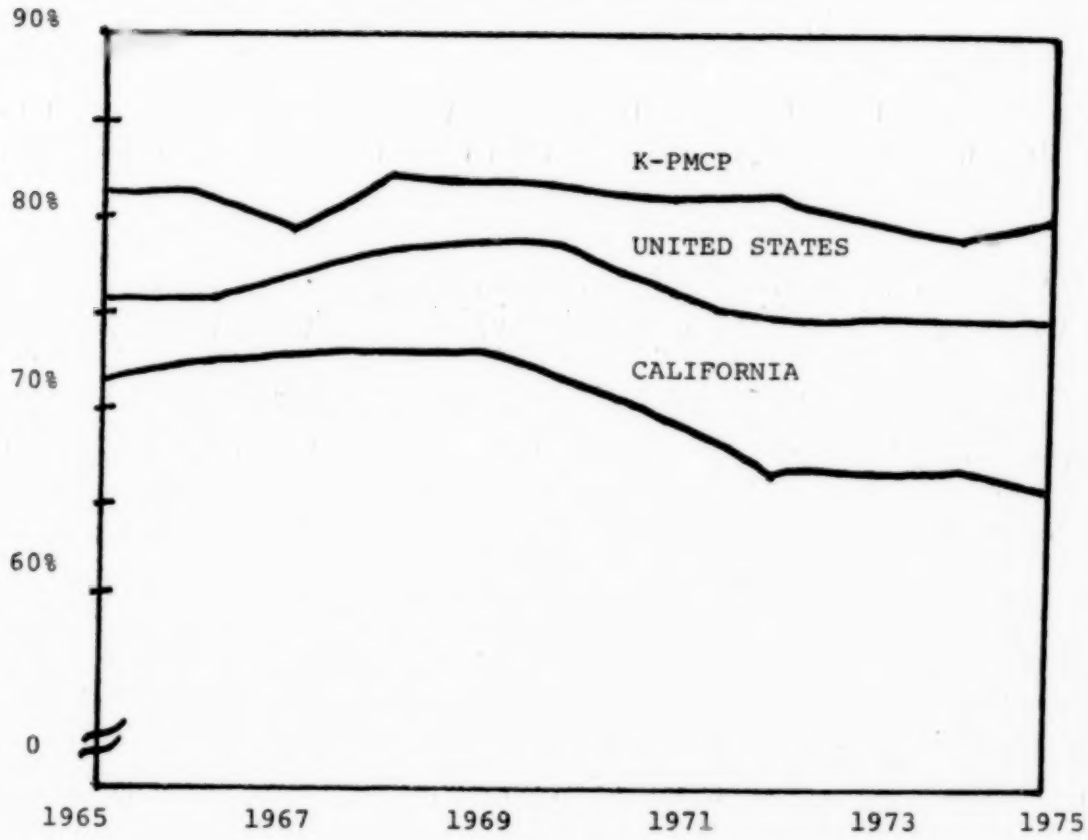


464; 1968: Table 1, p. 475; Table 3, p. 490; 1969: Table 1, p. 473; Table 3, p. 490; 1970: Table 1, p. 474; Table 3; p. 492); American Hospital Association, *Hospital Statistics,* Chicago, Illinois (1971: Table 1, p. 13; Table 3, p. 30; 1972: Table 1, p. 20; Table 5, p. 64; 1973: Table 1, p. 20; Table 5, p. 64; 1974: Table 1, p. 4; Table 5C, p. 48; 1975: Table 1, p. 5; Table 5C, p. 48); United States civilian resident population data are from *Social Security Bulletin,* Social Security Administration, DHEW, Vol. 39, No. 12, Table M-40, at 68 (December 1976). *California Population,* Department of Finance, State of California, Table 5, at 7 (May 1972), and for 1972-1975 are from *California Statistical Abstract, 1976,* State of California, Table B-1, at 6 (1976).

11. *Ibid.*

Exhibit 4

III. PERCENT AVERAGE OCCUPANCY[12]



12. *Ibid.*